

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2014
FORM APPROVED
OMB NO. 0938-0391

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|--|---|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 02/13/2014 | |
| NAME OF PROVIDER OR SUPPLIER TIMBERVIEW HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 000} | <p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00140612 and IN00141984 completed on 1/3/14.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/18/13.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00144034, IN00144168, IN00144315 and IN00144336.</p> <p>Complaint IN00140612: Corrected</p> <p>Complaint IN00141984: Corrected</p> <p>Survey dates: February 11, 12 and 13, 2014</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Survey team: Cynthia Stramel, RN, TC Yolanda Love, RN Heather Tuttle, RN 2/13/14 Lara Richards, RN 2/13/14</p> <p>Census bed type: SNF: 13 SNF/NF: 122 Total: 135</p> <p>Census payer type: Medicare: 23</p> | | | {F 000} | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| {F 000} | <p>Continued From page 1</p> <p>Medicaid: 105 Other: 7 Total: 135</p> <p>Timberview Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaints IN00140612 and IN00141984.</p> <p>Quality review completed on Febuary 17, 2014, by Janelyn Kulik, RN.</p> | {F 000} | | | |